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**INSTRUCTIONS FOR COMPLETING THE PAYMENT INFORMATION FORM FOR DIRECT DEPOSIT (TO A CHECKING OR SAVINGS ACCOUNT ONLY)**

The enclosed form must be completed as part of your application package in order to directly deposit your LRP disbursements and to ensure the uninterrupted flow of your loan repayment funds.

**To Be Completed by the Applicant**

Print or type your name.

Print or type your address including street, city, state and zip code.

Print or type your telephone number.

Print or type your social security number

**To Be Completed by Financial Institution Representative**

1. Print or type the name of the applicant's financial institution (where the applicant's checking or savings account is located).
2. Print or type the address of the applicant's financial institution (where the applicant's checking or savings account is located) including street, city, state and zip code.
3. The financial institution representative needs to print or type the 9-digit ABA routing number for transfer of applicant's funds.
4. Print or type the name(s) of the applicant's account whether it is a CHECKING account or a SAVINGS account. Identify only one type of account.
5. Print or type the account number of the applicant's account identified in item #4.
6. Print or type an X identifying the type of account where the applicant's funds will be deposited.
7. Sign your name, and print or type your title, telephone number, and the date.

***Applicant: Please verify the information, and sign and date the bottom of the form.***

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### PAYMENT INFORMATION FORM

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PROGRAM SUPPORT CENTER  
FINANCIAL MANAGEMENT SERVICE  
DIVISION OF FINANCIAL OPERATIONS

THE INFORMATION REQUESTED ON THIS FORM CONCERNS YOUR FINANCIAL INSTITUTION, YOUR ACCOUNT AT THAT INSTITUTION, AND PERSONAL INFORMATION WHICH NEEDS TO BE VERIFIED AND COMPLETED.

PRIVACY ACT STATEMENT

THE FOLLOWING INFORMATION IS PROVIDED TO COMPLY WITH THE PRIVACY ACT OF 1974 (P.L. 93-579). ALL INFORMATION COLLECTED ON THIS FORM IS REQUIRED UNDER THE PROVISIONS OF 31 USC 3322 AND 31 CFR 210. THIS INFORMATION WILL BE USED BY THE TREASURY DEPARTMENT TO TRANSMIT PAYMENT DATA BY ELECTRONIC MEANS TO YOUR FINANCIAL INSTITUTION. FAILURE TO PROVIDE THE REQUESTED INFORMATION MAY DELAY OR PREVENT THE RECEIPT OF PAYMENTS THROUGH THE AUTOMATED CLEARINGHOUSE PAYMENT SYSTEM.

CHECK ONE: FEDERAL EMPLOYEE \_\_\_\_\_ CONTRACTOR  VENDOR \_\_\_\_\_

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE (\_\_\_\_) \_\_\_\_\_

COMPLETE ONE OF THE FOLLOWING:

EIN\* (EMPLOYER ID #) \_\_\_\_\_ TIN (TAX ID#) \_\_\_\_\_

\*MAY BE YOUR SOCIAL SECURITY NUMBER IF YOU ARE AN INDIVIDUAL

**THE FOLLOWING INFORMATION MUST BE COMPLETED BY YOUR FINANCIAL INSTITUTION REPRESENTATIVE.**

1. NAME OF FINANCIAL INSTITUTION: \_\_\_\_\_
2. ADDRESS OF FINANCIAL INSTITUTION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. FINANCIAL INSTITUTION'S 9-DIGIT ABA ROUTING NUMBER FOR TRANSFER OF FUNDS: \_\_\_\_\_
4. DEPOSITOR ACCOUNT TITLE : \_\_\_\_\_
5. DEPOSITOR ACCOUNT NUMBER : \_\_\_\_\_
6. TYPE OF ACCOUNT : CHECKING \_\_\_\_\_ SAVINGS \_\_\_\_\_
7. SIGNATURE AND TITLE OF AUTHORIZED OFFICIAL AT FINANCIAL INSTITUTION  
  

|                                |                |
|--------------------------------|----------------|
| _____<br>SIGNATURE             | _____<br>TITLE |
| TELEPHONE NUMBER: (____) _____ | DATE: _____    |

**THE FOLLOWING IS TO BE COMPLETED BY PAYEE (APPLICANT)**

I HAVE VERIFIED THE INFORMATION ON THIS FORM.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

NOTE: ALL THE ABOVE INFORMATION MUST BE PROVIDED AND BOTH SIGNATURES ARE REQUIRED.